LONG COVID-19 CLINICS IN MERTON

REDUCING HEALTH INEQUALITIES CASE STUDY

AT A GLANCE

The service

Wide Way Medical Centre, East Merton PCN, South West London (SWL) in Sep-Nov 2021

Long COVID-19 clinics run by a GP, Care Coordinator and Health and Wellbeing coach.

Target population

People proactively identified as having symptoms of long COVID-19 through re calling patients from the patient system.

The intervention

Virtual and face-to-face group clinics to educate, share experiences and support each other.

Key drivers of sucess

Working together as one personalised care team.

GP and clinical directors who are engaged in proactive care.

Patient feedback:

"The meeting was helpful to talk and listen to others experiencing the same symptoms... Helped understanding and dealing with COVID-19 symptoms"

RESOURCES

Sample text inviting patients to Long Covid-19 video clinic

E-lfh group video clinics e-learning

Recording of webinar on how the three personalised care ARRS roles can work together

Key contacts: Agnieszka Sethi, Care Coordinator

THE CHALLENGE

- Different staff from the surgery, including receptionists, reported high rates of patients calling complaining of similar symptoms following COVID-19.
- Staff were unsure whether a GP appointment would be the best support for these patients.

THE ACTION PLAN

- Care Coordinator identified those who have had COVID-19 or reported long COVID-19 symptoms.
- Text campaign asking if these patients were still struggling with long term symptoms.
- Recalled these patients to identify exact symptoms, what their needs were, what they have tried so far, what other services might be useful.
- Care Coordinator led and managed running and set up of video clinics with GP and health and wellbeing coach, explaining the symptoms reported from recalls and offering advice.
- Evaluation of clinics to improve offer and include face-to-face clinics.

BARRIERS & TOP TIPS

Identifying patient need

- Listen to practice staff. Receptionists will know the types of patients who call, re call and book multiple GP appointments for the same issues. This is likely relate to an unmet need.
- Create an open multi-disciplinary team (MDT) environment, where common themes can be raised at meetings and ad hoc with managers. An open-door policy can help.
- Understand patient data, who is either a high utilisation patient indicating unmet need, or who is not accessing and failing to attend screenings or tests.

Capacity to carry out proactive work

- Start with areas that can alleviate pressure on the system, e.g. those with high reception or GP utilisation.
- Empower the personalised care team - have clear role descriptions and boundaries. Part of care coordination, social prescribing and coaching is proactively tackling health inequalities, Ringfence time for them to do this.